APPLICATION FOR REGISTRATION AS BUREAU APPROVED REHABILITATION FACILITY

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
Vocational Rehabilitation Division
P.O. Box 30016, Lansing, MI 48909-7516

Name of Entity _____

Address _____

_____ Zip Code _____

Phone Number (____) ____ — _____

Name of Chief Executive Officer _____Title_____

Check all that apply: ____ public ____ private ____ profit ____ non-profit

____ corporation (incorporated _____
(Date) (State)

____ private corporation/not incorporated

Social Security Number if individual _____ - ____ - _____

Michigan Tax Number if individual _____

1. If currently licensed, certified, approved or accredited by any public or private body, indicate name, address, licensure number if appropriate, expiration date; if more than one certification or accreditation, list them all:

_____

_____

_____

2. List names, number and type of professional staff (attach resumes):

_____

_____

_____

Continued on Reverse Side

3. Complete attached service and fee schedule indicating services you provide, units of service, and cost of each designated service.

4. Attach letters of recommendation from three (3) Michigan carriers and/or employers who are currently referring, or in the past have referred, cases for your services.

5. State what experience or qualifications you have in Workers' Compensation Rehabilitation.

6. Attach any supportive data, list of activities or other such information that you feel may assist in evaluating your application.

I authorize the Department of Consumer & Industry Services, Bureau of Workers' Disability Compensation to make any investigation of the application and supporting documents. I understand that any omission or misrepresentation may result in rejection or revocation of approval.

I hereby agree to be bound by all rules, regulations, policies and procedures as established by the Director and realize that violations may result in revocation of approval. I also agree to notify the Bureau of Workers' Disability Compensation of any violations or possible violations.

_____ _____

Print or Type Name | Title

_____ _____

Signature | Date

STATE OF MICHIGAN)
) ss.
County of)

Signed and sworn to before me on this

_____ Day of _____, 19_____

_____
Notary Public

_____County, Michigan

My Commission Expires:

_____, 19_____

Rev. 12/97

418.319 The Department of Consumer & Industry Services will not discriminate against any individual or group because of race, sex, religion age, national origin, color, marital status, disability , or religious beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

BUREAU APPROVED REHABILITATION FACILITY
SERVICE AND FEE SCHEDULE

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
Vocational Rehabilitation Division
P.O. Box 30016, Lansing, MI 48909-7516

Name of Entity _____ Phone (____) ___-_____

Address _____ Zip Code _____

I am/We are qualified to provide the following services for Workers' Compensation rehabilitation: (check each service you are qualified to provide)

Service	Unit of Service	Fee
Physical Rehabilitation:		
a. Evaluation		
b. Physician		
c. Physical Therapy		
d. Occupational Therapy		
e. Psycho-social		
f. Speech & Audiology		
g. Prosthetics & Orthotics		
h. Education		
i. Pain Management		
j. Counseling		
k. Other (Specify)		
Vocational Rehabilitation:		
a. Job Analysis		
b. Job Modification		
c. Analysis of Transferable Skills		
d. Labor Market Survey		
e. Vocational Testing		
f. Work Evaluation		
g. Work Adjustment		
h. Job Seeking Skills Training		
i. Job Development		
j. Job Placement		
k. Follow-Up		
l. On-The-Job Training		
m. Counseling		
n. Other (Specify)		

_____ _____

Date Signature